# CHANGE OF PRACTICE ADDRESS
# FOR ARNP WITH A (CAPA –CS)

**This form is to be used ONLY to notify KBN of an address change of the primary practice site. DO NOT use this form if there are any other changes to or a rescission of the CAPA-CS.**

ARNP Last Name

First Name

ARNP Registration Number:

**PREVIOUS PRACTICE ADDRESS:**

Address

City

State

Zip Code

**NEW ADDRESS OF PRACTICE SITE:**

Address

City

State

Zip Code

- -

Area Code Phone number

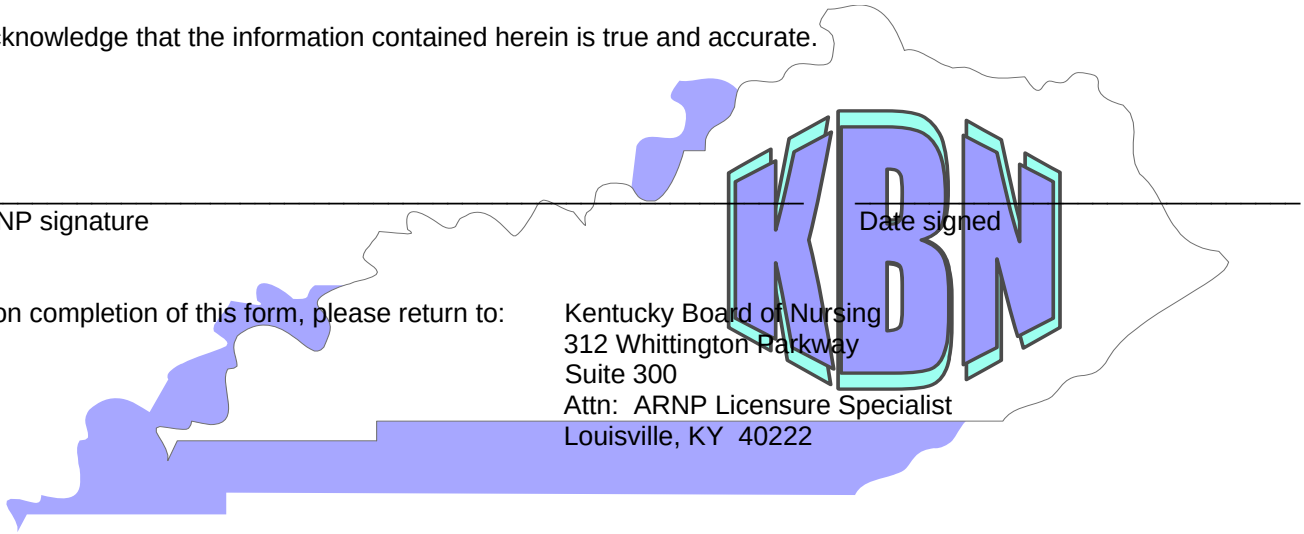
I acknowledge that the information contained herein is true and accurate.

ARNP signature

Date signed

Upon completion of this form, please return to:

Kentucky Board of Nursing
312 Whittington Parkway
Suite 300
Attn: ARNP Licensure Specialist
Louisville, KY 40222

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